Kuluski, K et al 2017 What are the Facilitators and Barriers to Integrated Health and Social Care in the Community? Insights from Care Providers. *International Journal of Integrated Care*, 17(5): A36, pp. 1-8, DOI: http://doi.org/10.5334/ijic.3337

CONFERENCE ABSTRACT

# What are the Facilitators and Barriers to Integrated Health and Social Care in the Community? Insights from Care Providers

17th International Conference on Integrated Care, Dublin, 08-10 May 2017

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**Introduction**: Growing numbers of people are living longer with co-existing health and social care needs and require access to integrated care in the community. Models of integrated care often focus on bridging the gap between various health care services (such as primary care and home care support), and less often between healthcare and services that address the determinants of health (such as housing, finances, food security, etc). Determining required elements of such health and social care integration is required to support appropriate, person centred models of care for people with complex care needs.

**Theory/Methods**: Focus groups with 24 care providers working in health and social care organizations across Toronto, Canada were conducted. Participants were presented with composite vignettes illustrating patients with significant health and social needs, nearing hospital discharge. The vignettes were used to prompt a discussion on i) how best to meet the needs of people with complex care needs in the community and ii) the barriers experienced when delivering care to this population. The sessions were taped, transcribed and analyzed for context using an inductive approach.

**Results**: Three broad categories to support care needs of complex patients and their families were determined: i) relationships as the foundation for care, ii) desired processes and structures of care and iii) barriers and workarounds for desired care.

**Discussion**: The relational aspect of care requires building trust; exploring factors that influence willingness to engage; and asking patients where to start. Desired processes and structures include a fulsome assessment of needs and capacity; broadening the structure of the team to include personal and peer support workers; integrating care proactively through interim care options and service co-location. Barriers included perverse incentives; issues of access; misaligned performance measurement; and reactive care.

**Conclusions**: (comprising key findings) Meeting the needs of people with complex care needs and their families requires authentic and consistent relationships with providers. Attention to non-medical factors including culture, personal goals and expectations, can also provide

insight into care preferences and levels of engagement. Teams that recognize and support less formalized roles of families, personal and peer support workers, are critical to the delivery of care to this population. The mobilization of needed supports would ideally occur before crisis and best managed if co-located and easier to access. These goals can be more effectively realized with the appropriate training, levers and incentives in place at the organization and policy levels.

**Lessons learned**: Putting these components into practice will be challenged by the orientation of health systems toward acute and episodic care; equipped to react quickly to problems after they arise, and then move onto the next case. Required is a fundamental shift to a system that is oriented to proactively support health and well-being.

**Limitations**: The proposed categories reflect the perspectives of health and social care providers and not patients and caregivers.

**Suggestions for future research**: Future research should engage patients and families to assess the extent to which the findings align with their needs and perspectives.

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**Keywords:** integrated care; complex care needs; health and social care; qualitative

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